MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

September 9-10, 2004

# A study of MA payment rates, payment areas, and risk adjustment mandated by the MMA

ISSUE: The plans that participate in Medicare Advantage (MA) are facing substantial changes. In 2004, the MA program began using a new system for setting local (county-level) payment rates, including the use of AAPCC rates, which are based on per capita local FFS spending. In addition, the MA program began using a new system for risk adjusting payments. In 2006, Medicare Advantage will have a new system of setting payments to local plans and will establish regional plans. The MMA directs MedPAC to complete a report that addresses three questions related to these changes. What factors underlie the geographic variation in AAPCC payment rates? What is the appropriate payment area for local plans? How well does the CMS-HCC, the risk adjustment system that CMS began using in Medicare Advantage in 2004, predict beneficiaries' costs? This brief contains preliminary analysis of some of the work we will do to complete this mandated report.

KEY POINTS: AAPCC rates vary widely among counties. This variation is a concern because previous use of AAPCC rates resulted in perceptions of inequity. Beneficiaries in counties with high rates (due to high per capita FFS spending) typically had more plans to choose from and were offered more generous benefits. We identified how much of the variation in per capita spending is due to county-level differences in the cost of inputs and special payments to hospitals in the form of IME, GME, and DSH. The remainder is attributable to providers' practice patterns, beneficiaries' preferences for care, and mix of providers.

Our analysis of the appropriate payment area for local plans focuses on the fact that counties—the current payment area—often have large year-to-year changes in per capita spending and that adjacent counties often have very different spending levels. Both these issues could be addressed with a larger payment area. As a starting point, we compared counties to a larger payment area that is based on metropolitan statistical areas and statewide rural areas. This larger payment area would reduce the frequency of large year-to-year changes in per capita spending and large differences in spending between adjacent counties. Whether this larger payment area is appropriate requires further investigation such as how closely it matches plans' market areas.

Finally, we used predictive ratios to evaluate the accuracy of the CMS-HCC. For a group of beneficiaries, a predictive ratio is the mean of their costliness predicted by a risk adjustment system divided by the mean of their actual costs. The closer a predictive ratio is to 1.0, the better the risk adjuster has performed. Our results indicate that the CMS-HCC performs much better than a risk adjustment system that uses beneficiaries' demographic information.

ACTION: At this meeting, staff seek the Commissioners' feedback on the content and methods staff have used and their thoughts on how to proceed as staff complete this study.

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